Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
8108 FOX CREEK TRAIL
DALLAS TX 75249

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-10-2407-01

MFDR Date Received
JANUARY 8, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "No Third Party Settlement No EOB Received No Third Party Settlement."

Amount in Dispute: $300.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The attached billing from Integra can not [sic] be paid, the claim was settled with the 3rd party carrier and the WC carrier is currently on holiday. The pltif atty [sic] will not provide the settlement documents so that we can determine the exact amount of claimant's settlement."

Response Submitted by: Gallagher Bassett Services, 6504 International Pkwy, #2100, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2009 May 15, 2009 June 18, 2009	CPT Code 90801, 99080-73 and 99212	$300.10	$285.67

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code Section 417.002 sets out the guidelines for recovery in third-party action.
2. 28 Texas Administrative Code §129.5 sets out the procedures for filing Work Status Reports.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - A – Service is denied for lack of proof of pre-authorization.
   - 215 – Based on subrogation of a third party settlement.

Issues

1. Did the respondent support that a Third Party Settlement occurred?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier initially denied the psychiatric diagnostic interview examination using denial code A – "Service is denied for lack of proof of pre-authorization." The insurance carrier did not maintain the denial code upon reconsideration and denied the services using denial code 215 – "Based on subrogation of a third party settlement." On February 10, 2011 Medical Fee Dispute Resolution requested a copy of the third party settlement in order to complete the audit for this dispute. The insurance carrier, or its agent, has not responded or submitted the requested documentation as of May 15, 2013; therefore, the disputed dates of service will be reviewed in accordance with Division rules and the Labor Code.

   28 Texas Administrative Code §134.203(c) states, in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83… (2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The MAR for the payable services may be calculated by (2009 TDI-DWC MEDICARE CONVERSION FACTOR) x Facility Price = MAR.

   - CPT Code 90801 – (53.68 ÷ 36.0666) x $147.04 = $218.85
   - CPT Code 99212 – (53.68 ÷ 36.0666) x $34.82 = $51.82

   In accordance with 28 Texas Administrative Code 129.5(i) notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section. Review of the work status report submitted by the requestor supports reimbursement.
2. Review of the submitted documentation finds the requestor is due reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $285.67.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $285.67 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 16, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.